STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIELDS HOUSE	2288 NICHOLAS CT SEYMOUR, IN47274

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R0000	This visit was for a State Licensure Survey. Survey dates: April 5, 6, 2011 Facility number: 004376 Provider number: 004376 AIM number: N/A Survey team: Amy Wininger, RN TC Melinda Lewis, RN Marla Potts, RN Sharon Whiteman, RN (April 5, 2011) Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 07 The state findings are cited in accordance with 410 IAC 16.2-5 in regard to the Residential State Licensure Survey. Quality review completed on April 8, 2011 by Bev Faulkner, RN	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0006	(f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview and record review, the facility failed to ensure a resident who required 24 hour per day comprehensive nursing care, required total assistance with toileting and transferring, and was not medically stable in that the resident had a pressure ulcer which worsened while residing in the facility and had repeated falls, was not discharged in order to meet the residents comprehensive care needs	R0006	**Citation #1 R 006 410 IAC 16.2-5-0 (f) (1-5) Scope of Residential Care What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #11 and resident #2 was re-assessed and determined to be appropriate for our residentially licensed facility. Resident #11 has a third party provider implemented in collaboration with Shields House to ensure the licensed and unlicensed needs of this resident	04/28/2011

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	(Resident 11) and failed to ensure a resident who refused to follow the smoking policy was discharged due to putting herself and others in danger. (Resident #2) for 2 of 7 residents reviewed for meeting the requirements for residential care in the sample of 7. Findings include: 1. Resident #11 was identified by the Wellness Director on the initial tour of the facility on 4/5/11 at 9:30 a.m., as being dependent on staff for care and not interviewable. Resident #11 was observed from 9:30 a.m. through 12:30 p.m. to be sitting in a high back wheelchair in the dining room. A Foley catheter drainage bag was observed hanging beneath the chair. At 1:30 p.m., a home health nurse was observed changing the dressing to the resident's left heel. The area was observed to cover the entire heel, with a open wound, red base in the center, loose yellow skin surrounding the open area, with the		are met. Resident #11's wound is currently showing improvement and is reviewed by the Wellness Director weekly. Resident #2 was re-assessed utilizing a smoking assessment and was determined to need assistance from staff regarding providing cigarettes and smoking paraphernalia upon request of the resident for monitoring purposes. The Residence has removed cigarettes and smoking paraphernalia and will provide to the resident upon request under staff supervision. Resident #2 was educated by the Regional Director of Quality and Care Management to our policy and that future noncompliance with plan will result in issuance of a notice of involuntary discharge. Resident #2 understands in the event a notice of involuntary discharge is issued we will provide ample notice and assist with alternative placement. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. All third party providers will be in-serviced for coordination of care within Shield's House. Wellness Director and Resident Director will reassess all residents upon change of condition and/or every 6 months.All new residents that are smokers will have a smoking	

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	tissue around the yellow a deep dark red. The home health nurse indicated the resident had returned from a hospital stay on 3/28/11 with a blister to the heel. She further indicated she thought the heel was a Stage 2 pressure ulcer and physical therapy was debriding it. The home health nurse indicated home health provided all treatments for the ulcer. Resident #11 was observed at 2:20 P.M., on 4/5/11 to be transferred to bed from the wheelchair by QMA [Qualified Medication Aide] #1 and CNA [Certified Nursing Assistant] #2. The staff members lifted the resident by putting their arms under hers and totally lifting her into the bed. The resident did not bear weight. The resident was positioned in the bed with a pillow between her feet, allowing her left heel to lay flat on the pillow. The resident's urine appeared a very dark tea color and appeared concentrated.		assessment upon admission, after 30 days, and then every 6 months unless change of condition. Each existing and new resident smokers will be educated by Residence Director and Wellness Director to ALC policy and any future noncompliance will result in an involuntary discharge, we will provide ample notice and assistance for alternate placement. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and staff were re-educated to our policy and procedure regarding our residency agreement referencing our “smoke free” facility as well as our Assisted Living Decision Tree as to reporting of such instances. The Wellness Director and Residence Director were also re-educated to their role in educating our resident population that failure to comply with our smoking policy will result in termination of their lease if an alternative plan or agreement cannot be reached to ensure further compliance. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** For the next three months the Wellness Director or designee will	

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	Resident #11's clinical record was reviewed on 4/5/11 at 11:00 A.M. The most recent Assessment and Negotiated Service Plan Summary, dated 11/18/10, indicated "staff to assist during bathing twice weekly," requires physical assist with showering, unable to use the bathroom independently, uses protective undergarments, needs staff to empty catheter drainage bag, staff to assist with catheter. empty bag every shift, uses a walker and manual wheelchair for mobility, resident requires staff to escort to area for exercise, activities and meal frequently as she gets nervous of not being able to find way, requires assistance of two personnel or the use of a mechanical lift for transfers, staff must assist home health with changing catheter to attempt to keep resident calm, special services-home health or other outside provider, resident becomes anxious at times and may need to be calmed by staff.		perform a random weekly review of resident's who smoke to ensure compliance with our smoking policy and procedure. Resident's will be assessed utilizing our smoking assessment upon admission and as needed if non compliance is suspected. Residents who are found to be non compliant will be re-educated with a plan to minimize risk for future occurrence. In the event the plan is evaluated and found unsuccessful arrangements will be made for alternative placement for that individual. Findings will be reviewed within the next three months as to the frequency of continued monitoring. Findings suggestive of compliance will meet the criteria for cessation of our weekly review. Resident's will be reviewed ongoing upon admission and as needed and corrected through the facility's QA process. **By what date will the systemic changes be completed?** Compliance Date: May 15, 2011	

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	A nursing comprehensive evaluation, dated 3/24/11, indicated the resident had returned from a hospital stay with a 7 cm [centimeter] left heel blister yellowish, closed. The evaluation indicated home health notified of orders and "resident lethargic and only opens her eyes when she is stimulated..." A home health note, dated 3/29/11, indicated "Pt sent to ...hospital on 3/12/11 and came back 3/28/11. Pt had been sent to ER [emergency room] related to increased agitation and crying out..home health care was unaware pt had been admitted to hospital called and received orders to see pt today and anchor Foley catheter...this was removed at hospital obtained 600 ml yellow urine without difficulty...assessed left heel blister, it has opened and drained moderate amount serous drainage measured 6.0 cm by 7 cm covered and padded with gauze and secured with Coban [a product to secure dressings]...will call Dr			

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	for wound care orders...." Home health notes, dated 3/29/11, indicated "Pt was hospitalized for exacerbation of Alzheimer's and was released before home health was notified...now has decreased self care ability....with large open blister on left heel...Physical therapy for evaluation with wound care." Notes, dated 3/30/11, indicated physical therapy would see the resident one time weekly for six weeks for management of left heel wound to include sharp abridgement as indicated, dressing changes as per orders, cleanse left heel with normal saline, apply Allevyn foam and calcium alginate. secure with Kerlix and tape. Assess wound: pressure ulcer left posterior heel, unstageable, suspected deep tissue injury, .79 in length and .98 in width, small amount exudate, tissue bed-pink, red, dark red. The facility lacked any documentation of what the pressure area looked like between 3/28/11			

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	and when assessed by home health on 3/29/11, or any interventions implemented. The facility lacked any service plan to treat the pressure ulcer. During interview with the Wellness Director on 4/5/11 at 11:45 A.M., indicated she had gave the Health Facility Administrator some updates on the service plans to type in but those could not be located. Resident Service Notes indicated the following: "7/13/11 staff entered resident room to empty catheter, resident was on floor next to bed feet toward bed head toward closet, chair was turned over in from of her, EMS (emergency medical services) was called, they checked her over and assisted up...." "9/2/10 6:30 p.m. res found on floor by CNA ...sent to hospital...sent back to facility 9 p.m. assisted to bathroom by CNA and helped get ready for bed..."			

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	"9/8/10 3:30 p.m. Res got up by self from dining room and fell..." "10/7/10 11:30 p.m. doing rounds and found res on floor toward foot of bed crying and shaking...dispatched 911....3 A.M. call (hospital)...they will be keeping her she has a broken left hip..." "10/8/10 230 p.m. spoke with....discharge planner...requested low hospital bed and wheelchair order...questionable fracture of left hip..." A note, dated 10/10/10 at 7 p.m., indicated the resident had a deformity of the hip causing severe pain not a fracture and had pneumonia. "10/13/10 8 p.m. assisted to bathroom with assist of 2 some difficulty transferring resident afraid of falling, pushing against staff..."			

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	"1/14/11 250 a.m. other CNA heard her bed alarm going off we went into room she was sitting non side of bed trying to get up...was upset saying her grandpa needed her..." "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed resident....will request smaller cushion depth with non slick surface." Notes indicated the resident was sent to the hospital 3/13/11 and returned 3/24/11. "3/28/11 236 a.m. went to check on resident found on floor next to bed, called EMS , they put her back to bed...." "3/28/11 call received resident fell. call to Dr...office to discuss recent falls and requested home health referral possible evaluation for safety mat and consideration to anchor Foley catheter as resident			

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states she is getting up to go to bathroom."

The service plan included no interventions added for falls prevention.

During interview with the Wellness Director, on 4/6/11 at 11:00 A.M., she indicated the resident was seen by a home health nurse and physical and occupational therapies, but not any home health aides to assist in day to day care.

2. The clinical record of Resident #2 was reviewed on 04/05/11 at 10:00 A.M. The record indicated Resident #2 had diagnoses that included, but were not limited to, Chronic Pain and Hypertension [high blood pressure]. Resident #2 was observed on 04/05/11 at 10:45 A.M. in the facility courtyard sitting on her electric wheelchair.

On 04/05/11 at 10:45 A.M., three areas of burned carpet were noted in the living area of Resident #2's

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	apartment. The Assessment and Negotiated Service Plan of Summary, dated 03/15/11, indicated Resident #2 was a smoker and required no assistance with managing cigarettes and smoke safely and without assistance outside in designated smoking area. The Service Plan further indicated Resident #2 had no problems with recalling the day, date, time, or location. The Resident Service Notes, dated 01/23/11 at 12:00 P.M., indicated, "Res. [resident] found smoking in BR [bathroom] of apartment. putting [sic] ashes and cigarettes in commode. Staff reminded res. this is against facility policy to smoke inside the building. Res. stated 'I know but I can't go outside and [name of Wellness Director] DoN and I go way back she knows smoking [sic] in here and it ok with her..." The Resident Service Notes, dated			

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	01/23/11 at 5:00 P.M., indicated, "Administrator informed of res. smoking in bathroom. Administrator will address issue in a.m. CNA [Certified Nursing Assistant] to monitor for any further smoking. The Resident Service Notes, dated 02/08/11 at 1:00 P.M., indicated, "Spoke with resident extensively about only designated smoking area was outside in the courtyard re-educated about smoking hazzerds [sic]. Resident states she understands she can not smoke inside..." The Resident Service Notes, dated 03/20/11 at 1:00 P.M., indicated, "Continues to sneak cigarettes in her room during third shift informed her this could result in a [sic] eviction notice because this puts other resident at risk..." In an interview with the RD [Residence Director] on 04/06/11 at 9:45 A.M., he indicated he had			

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	spoken to Resident #2 on or about 03/28/11 or 03/29/11 about smoking in her room. The Residence Director further indicated he could provide no documentation of the conversation. In an interview with the Regional Nurse on 04/06/11 at 11:00 A.M., he indicated he was unable to provide a smoking assessment for Resident #2. The Policy and Procedure for Smoking provided by the RD on 04/06/11 at 10:00 A.M. indicated, "...Smoking...3. Resident...may smoke in outside designated areas only ...7. a resident's ability to smoke in a safe manner should be assessed during the Negotiated Service Planning...as needed. 8. All incidents of unsafe smoking should be documented in...their Negotiated Service Plan should be revised, if needed..."			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to revise the service plan to include fall prevention and care of a pressure ulcer interventions, for Resident #11 and for fall prevention for Resident #9 for 2 of 5 residents reviewed for service plan updates	R0217	**Citation #2** **R 217** **410 IAC 16.2-5-2 (e) (1-5)** **Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #9 and #11 was re-assessed by the Wellness Director	04/28/2011

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	and revisions in a sample of 7. Findings include: 1. Resident #11 was identified by the Wellness Director on the initial tour of the facility on 4/5/11 at 9:30 a.m., as being dependent on staff for care and not interviewable. Resident #11 was observed from 9:30 a.m. through 12:30 p.m., to be sitting in a high back wheelchair in the dining room. A Foley catheter drainage bag was observed hanging beneath the chair. At 1:30 p.m., a home health nurse was observed changing the dressing to the resident's left heel. The area was observed to cover the entire heel, with a open wound, red base in the center, loose, yellow skin surrounding the open area, with the tissue around the yellow being a deep dark red. The home health nurse indicated the resident had returned from a hospital stay on 3/28/11 with a blister to the heel. She further indicated she thought		utilizing the service level assessment and the negotiated service plan as to falls and pressure ulcer intervention. Resident #11 had interventions implemented to minimize the risk for future falls and impaired skin integrity along with a plan to promote wound healing. Resident #9 had interventions implemented to minimize the risk for future falls. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and staff were re-educated to our policy and procedure regarding falls management and service planning in order to ensure compliance with Indiana state ruling 410 IAC 16.2-5-2 (e) (1-5) Evaluation. The Wellness Director and/or Designee will review incident reports to ensure appropriate evaluation of residents is completed and documented within our service notes after falls. Residents experiencing a fall will also have their service plans reviewed and updated to ensure appropriate interventions are implemented in order to minimize	

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	the heel was a Stage 2 pressure ulcer and physical therapy was debriding it. In interview at this time, the home health nurse indicated home health provided all treatments for the ulcer. Resident #11's clinical record was reviewed on 4/5/11 at 11:00 A.M. The most recent Assessment and Negotiated Service Plan Summary, dated 11/18/10, indicated "staff to assist during bathing twice weekly" requires physical assist with showering, unable to use the bathroom independently, uses protective undergarments, needs staff to empty catheter drainage bag, staff to assist with catheter. empty bag every shift, uses a walker and manual wheelchair for mobility, resident requires staff to escort to area for exercise, activities and meal frequently as she gets nervous of not being able to find way, requires assistance of two personnel or the use of a mechanical lift for transfers, staff must assist home health with		the risk for future occurrences. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** For the next three months the Wellness Director or designee will perform a random weekly review of resident incident reports, service notes, and service plans to ensure residents who experience a fall are evaluated with appropriate documentation and service planning as to interventions attempted in order to minimize the risk for future falls. Findings will be reviewed within the next three months as to the frequency of continued monitoring. Findings suggestive of compliance will meet the criteria for cessation of our weekly review. Resident's will be reviewed ongoing upon admission and as needed and corrected through the facility's QA process. **By what date will the systemic changes be completed?** Compliance Date: May 15, 2011	

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	changing catheter to attempt to keep resident calm, special services-home health or other outside provider, resident becomes anxious at times and may need to be calmed by staff. A nursing comprehensive evaluation, dated 3/24/11, indicated the resident had returned from a hospital stay with a 7 cm left heel blister yellowish closed. The evaluation indicated home health notified of orders and "resident lethargic and only opens her eyes when she is stimulated..." A home health note, dated 3/29/11, indicated "Pt sent to ...hospital on 3/12/11 and came back 3/28/11...assessed left heel blister, it has opened and drained moderate amount serous drainage measured 6.0 cm by 7 cm covered and padded with gauze and secured with Coban [a product to secure dressings]...will call Dr for wound care orders...." Home health notes dated 3/29/11 indicated Pt was			

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	hospitalized for exacerbation of Alzheimer's and was released before home health was notified...now has decreased self care ability....with large open blister on left heel...Physical therapy for evaluation with wound care. Notes, dated 3/30/11, indicated physical therapy would see the resident one time weekly for six weeks for management of left heel wound to include sharp debridement as indicated, dressing changes as per orders, cleanse left heel with normal saline, apply Allevyn foam and calcium alginate. secure with Kerlix and tape. Assess wound: pressure ulcer left posterior heel, unstageable, suspected deep tissue injury, .79 in length and .98 in width, small amount exudate, tissue bed-pink, red, dark red. The record lacked any documentation of what the pressure area looked like between 3/28/11 and when assessed by home health on 3/29/11, or any interventions implemented. The facility lacked			

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	any service plan to treat the pressure ulcer. During interview with the Wellness Director, dated 4/5/11 at 11:45 A.M., indicated she had given the Health Facility Administrator some updates on the service plans to type in but those could not be located. Resident Service Notes indicated the following: "7/13/11 staff entered resident room to empty catheter, resident was on floor next to bed feet toward bed head toward closet, chair was turned over in from of her, EMS (emergency medical cal services) was called, they checked her over and assisted up...." "9/2/10 6:30 p.m. res [resident] found on floor by CNA ...sent to hospital...sent back to facility 9 p.m. assisted to bathroom by CNA and helped get ready for bed..." 9/8/10 3:30 p.m. Res got up by self			

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	from dining room and fell..." "10/7/10 11:30 p.m. doing rounds and found res on floor toward foot of bed ed crying and shaking...dispatched 911....3 A.M. call (hospital)...they will be keeping her she has a broken left hip..." "10/8/10 230 p.m. spoke with....discharge planner...requested low hospital bed and wheelchair order...questionable fracture of left hip..." A note, dated 10/10/10 at 7 p.m., indicated the resident had a deformity of the hip causing severe pain not a fracture and had pneumonia. "10/13/10 8 p.m. assisted to bathroom with assist of 2 some difficulty transferring resident afraid of falling, pushing against staff..." "1/14/11 250 a.m. other CNA heard her bed alarm going off we went			

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	into room she was sitting on side of bed trying to get up...was upset saying her grandpa needed her..." "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed resident....will request smaller cushion depot with non slick surface." Notes indicated the resident was sent to the hospital 3/13/11 and returned 3/28/11. "3/28/11 236 a.m. went to check on resident found on floor next to bed, called EMS , they put her back to bed...." 3/28/11 call received resident fell. call to Dr...office to discuss recent falls and requested home health referral possible evaluation for safety mat and consideration to anchor Foley catheter as resident states she is getting up to go to bathroom."			

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	The service plan included no interventions added for falls prevention. 2. The clinical record for Resident #9 was reviewed on 4/5/11 at 11:00 A.M. The record indicated Resident # 9 had diagnoses that included, but were not limited to, diabetes and depression. The Assessment and Negotiated Service Plan Summary, dated 3/8/10, indicated "...Have you ever fallen? (There was a x in the box next to this question with no other documentation)..." The Resident Services Notes, dated 8/5/10 at 7:00 A.M., indicated "CNA reported Rd [resident] found on floor in front of commode. Upon entering room Rd sitting on floor facing commode. Rd A & O x 3 [alert and oriented times three]. Denies hitting head. Denies any			

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	injury...Rd unsure how she feel off commode. States "I was sitting on the commode my clothes were on the floor...I reached down and found myself on floor"..." The Resident Services Notes, dated 9/21/10 at 6:00 P.M., indicated "Res called me to room, found on floor, went got nurse to assess. Res stated she wasn't hurt...no apparent injury. Notified Adm [administrator], regional RN, and family. Faxed MD." The Resident Services Notes, dated 9/27/10 at 5:00 A.M., indicated "Resident was found on floor in front of room door in hallway saying help. Immediately asked if she was OK. (Name) picked her up and sat her in chair. She said she was OK. I then called her son. I then told him that his mother had fallen off couch and I had seen her on floor in hall by her door. He asked if she was OK. I said yes and then told him that (name) had picked her up when she said she			

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	was OK. He said it was fine. I also told him that I asked her how she fell, got in hall and where her pendant was. He said all right. She then asked for coffee after I had called and informed (Residence Director's name) about incident. She had also refused to be sent out on or for anyone to be called to help her up after coffee she went and got dressed and came back to dining area for a while." In an interview with the Regional Nurse, on 4/6/11 at 10:00 A.M., he indicated the person which assisted Resident #9 off the floor on 9/27/10 was a visitor. The Resident Services Notes, dated 9/27/10 at 1:00 P.M., indicated "Rd [resident] on sidewalk in front of facility. Appears to have slid out of w/c. denies pain or injury." The Resident Services Notes, dated 9/30/10 at 1:00 P.M., indicated "Res on floor in living room. She used pendent to call for assistance			

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	denies injury and refused to go to ER. Moves all ext [extremities]without difficulty Assisted to w/c res transferred self to toilet from w/c without difficulty The Resident Services Notes, dated 10/7/10 at 1:30 P.M., indicated "Res paged CNA, Res stated she was cleaning her room when she slipped on a magazine and fell hitting her head on A/C unit. Res refused to go to ER for exam. Signed refusal to transport. Vital signs within N/L [normal limits]. (name) W/D [Wellness Director], (name) R/D [Residence Director], Son (name) and Dr (name) all notified. Res also stated R [right] hip and R thigh hurt from previous falls..." The Resident Assessment and Negotiated Service Plan Summary, dated 11/3/10, indicated the resident had fallen in the last 3 months. The Resident Services Notes, dated			

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	11/10/10 at 7:25 A.M., indicated "Res pushed pendant, CNA went to see what res needed, found res on buttocks in front of door. Res stated R [right] knee gave out, when going into B/R [bathroom]. CNA went and got nurse (name) nurse did assess and we got res up. No red area on buttocks denies pain...Res refused to go to ER signed refusal to transport. Called son (name), (name) W/D [Wellness Director], (name) RD [Residence Director], (name) Regional Nurse and Dr (name)." The Nursing Comprehensive Evaluation, dated 11/14/10, indicated "...Resident is on a 2 hour check at night due to a fall this year for which she stated she could not alert staff. Staff now check on her regularly during the night and assure emergency pendent is within reach of resident at all times..." The Resident Services Notes, dated 11/24/10 at 7:50 (no A.M. or P.M.), indicated "Called to res room CNA			

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	stated (Resident # 9) is in the floor. Upon entering the room res sitting in floor in front of sofa with back against sofa...Res denies hurting self, denies hitting head..." The Resident Services Notes, dated 12/2/10 at 10:00 P.M., indicated "Res [resident] rang call pendant went to room she was on floor in front of couch...She didn't know what happened. Refused to go to ER called her son he came in and picked her up. WD [wellness director] and RD [residence director] called Dr. faxed. Family aware no injury noted at this time." The Resident Services Notes, dated 1/10/11, no time, indicated "Responded to (Resident #9's name) room- observed resident sitting on floor between her bed and the closet doors. Examined resident- she stated she was unplugging her electric w/c when she lost her balance. Denies pain or discomfort and is refusing transport to the emergency room for			

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	assessment...Small 1.5 cm skin tear observed L [left] wrist..." The Resident Services Notes, dated 1/19/11 at 2:15 A.M., indicated "Resident turned call pendant on when CNA entered room she was on floor sitting up in living room. A wicker rocker was laying on her she said she was going to sit down and missed the chair. She said she was going to sit down and missed the chair. She used the arm of the chair to help pull herself up. She refused to go to ER said she wasn't hurt. No apparent injuries at this time...RN called, Resident Director called, Resident's son called. Dr notified." The Resident Services Notes, dated 1/19/11 at 4:30 A.M., indicated "Call resident had been found on floor in her room. Assessed- no c/o pain or discomfort refusing to be transported to the emergency room for assessment. No areas of erythemia (sic), or skin break down R/T [related to] fall...Discussed with resident the desire for her to			

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	ring for assistance when needed. Resident states she feels she has decreased feeling in her feet from her neuropathy. I informed her that made it even more important to call for assistance." The Resident Services Notes, dated 1/31/11 at 8:40 A.M., indicated "Called to resident's room to assess resident. Observed resident on the floor sitting in front of her couch. Assessed resident- denies pain or discomfort..." The Resident Services Notes, dated 2/8/11 at 7:15 A.M., indicated "Received a call stating resident was found sitting on floor and she refused ER [emergency room] transport and her family had been called to help her up as requested by resident. Upon arrival to resident's room she was already sitting on her couch. Discussed what happened and she stated she "had just sat down too soon." The Resident Services Notes, dated			

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	2/8/11 at 9:00 A.M., indicated "Dr (name) notified of fall and asked about possible appointment so he could evaluate recent falls..." The Resident Services Notes, dated 2/8/11, no time, indicated "Resident fell- assessed. No c/o [complaints of] pain or discomfort. No bruising, erythemia (sic), abrasion observed." The Resident Services Notes, dated 2/13/11, no time, indicated "Resident fell in bathroom- stated she did not know how she got on bathroom floor. Family called and assisted resident up. Small 1 x [by] 2 bump on rt [right] side of head ice applied. Refused transport to emergency room for assessment." The Resident Assessment and Negotiated Service Plan Summary lacked documentation of updates or revisions since 11/03/10. In an interview with the Wellness Director on, 04/06/11 at 10:00 A.M., she indicated the Resident			

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	Assessment and Negotiated Service Plan Summary, dated 11/03/10, was the most recent one.			

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R0239	(c) Each facility shall choose whether or not it administers medication or provides residential nursing care, or both. These policies shall be delineated in the facility policy manual and clearly stated in the admission agreement. Based on observation, interview and record review, the facility failed to ensure that nurses and QMA's [Qualified Medication Aides] administered drugs in accordance with the facility's medication policies to assure medications were given according to physicians orders; in that the facility allowed family members and personal friends to set up weekly pill boxes from which staff administered the medications without checking the medication labels for 2 of 5 residents reviewed for medication administration in a sample of 7. (Resident #2 and #10) Findings include: The policy and procedure for Medication Distribution Methods, obtained from the Wellness Director on 4/4/11, not dated, indicated "Medications and	R0239	**Citation #3 R 239 410 IAC 16.2-5-4 (c) Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #2 and #10 were re-assessed by the Wellness Director utilizing the medication self administration assessment. Resident #2 and #10 were deemed to be incapable of self administration of medication. The resident's physician was notified with an order obtained for Shields House licensed staff to admin medications per physician order. Resident #2 and #10 had their service plan updated to include Residence to administer medication as indicated by the physician. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director	04/28/2011

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	treatments are administered to residents as determined by review of their medication status and in accordance with physician orders, and by state law and regulations. The six rights of medication and administration are observed-right resident, right medications, right dose, right form and right route.... The policy and procedure for "Residents Self Management of Medications," not dated, with a faxed date of 4/5/11, obtained from the Wellness Director on 4/6/11 at 9:30 A.M., indicated " If the medication self administration assessment, shows that the resident should be capable of self administering medications, the nurse....when developing a plan for residents who need reminders to self administer the medications that are stored in their apartments, be sure to address any potential problems in the Negotiated service Plan. For example, when medications are kept in a medi-planner...be sure to address on		and staff were re-educated to our policy and procedure regarding falls management and service planning in order to ensure compliance with Indiana state ruling 410 IAC 16.2-5-2 (e) (1-5) Evaluation. The Wellness Director and/or Designee will review incident reports to ensure appropriate evaluation of residents is completed and documented within our service notes after falls. Residents experiencing a fall will also have their service plans reviewed and updated to ensure appropriate interventions are implemented in order to minimize the risk for future occurrences. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director or designee will perform an ongoing quarterly assessment of residents who self administer medications utilizing the medication self administration assessment to ensure continued compliance. Findings will be reviewed and corrected through the facility QA process. **By what date will the systemic changes be completed?** Compliance Date: May 15, 2011	

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	the service plan the family member responsible for setting them up accurately and coming in to the residents to reset them after a spill or change in physician orders. If staff is to remind a self-med resident that it is time to take medications, the MAR entry the staff will initial might read: staff to remind resident of medication times, then list the times staff will perform task...Note: Under no circumstance should staff open a medi-planner and assist with medication administration if the medi-planner is filled by someone other than a nurse..." 1. During observation of the medication pass on 4/5/11 at 9:30 A.M., QMA #1, indicated she was going to administer Resident 10's medications. QMA #1 took a weekly medi-planner (a plastic container used to set up medications with 4 times for each of the 7 days) out of the medication drawer, and remove 11 medications from the container. QMA #1			

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	indicated the resident's family set the medications up and then facility staff administered the medications and signed off on the Medication Administration Record as having done so. No medication bottles were in the medication cart. During interview with Resident #10 on 4/4/11 at 10:30 A.M., she indicated she really did not know what all the medications were she took. She indicated her husband used to set up her medications and now one of her children did. She indicated she would not want to have the weekly box set up and take them herself in her room. She indicated all the medications were kept in her bathroom in a cabinet. The medications were observed with labels available. Resident #10's clinical record was reviewed on 4/4/11 at 10:00 A.M. Diagnoses included but were not limited to: Dementia. The resident's Medicating Self Administration assessment, dated			

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	1/29/11, indicated the resident was capable of self administering, the form was not completed to indicated if the resident "chooses to participate in program." The form also included a section entitled "Plan" and "Comments," and neither were completed. The Service Assessment/Negotiated Service Plan, dated 1/29/11, indicated under "medication assistance," the resident was able to manage your medications independently, including storage, set up, taking and reordering medications. For "Do you need reminders only in order to safely take your medications, (you are able to order, store, setup, and take all medication without assistance or supervision)," the answer was "no." The April 2011 MAR [Medication Administration Record] indicated Resident #10 received "Jannuvia [sic] [for Diabetes] 50 mg [milligrams] daily,			

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	Hydroxyzinepam [sic] [for Seasonal Allergies] 25 mg twice daily, Aricept [for Dementia] 5 mg daily, Lasix [a diuretic] 40 mg daily, Metformin [for Diabetes] 500 mg daily, Tylenol Arthritis [for pain] 650 mg twice daily, Detrol LA [for urinary reflux] 4 mg daily, Glipizide ER [for Diabetes] 10 mg twice daily, Nexium DR [for Gastroesophageal Reflux Disease] 40 mg daily, Prednisone [anti-inflammatory] 5 mg daily, Sertraline HCl [for depression] 100 mg daily." 2. The clinical record of Resident #2 was reviewed on 04/05/11 at 10:00 A.M. The record indicated Resident #2 had diagnoses that included, but were not limited to, Chronic Pain and Hypertension [high blood pressure]. Resident #2 was observed on 04/05/11 at 10:45 A.M., in the facility courtyard sitting on her electric wheelchair. On 04/05/11 at 9:45 A.M., QMA #1 was observed to retrieve a			

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	medi-planner from the medication cart, open a section, pour the contents into a medication cup, and dispense the pills to Resident #2. The Assessment and Negotiated Service Plan of Summary, dated 03/15/11, indicated Resident #2 required assistance with administration or supervision of 10 or more routine medications per day or more than 4 medication assistance times per day. The Service Plan further indicated Resident #2 had no problems with recalling the day, date, time, or location. In an interview with Resident #2 on 04/05/11 at 10:45 A.M., the resident indicated a friend sets up all of her medications and gives the pill box to the nurses to give to her. A physician fax transmission/phone order, dated 02/22/11, indicated, "Concerns: Res. [resident] is now being given her med by staff at this time."			

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	The Physician's Order Recap for December 2010 indicated an order for "Self administration of meds: Yes was circled." The Physician's Order Recap for March 2011 was reviewed on 04/05/11 at 10:00 A.M., and indicated, "Ancillary Orders... Self Administration of Meds: Yes No." The document lacked any indication that Yes or No had been chosen by the physician. The Medication Self-Administration Assessment, dated 12/31/08, indicated "Physician agrees for resident to self administer..." The Medication Self-Administration Assessment, dated 03/15/11, indicated Resident #2 required assistance with "5. Tell time and when medication is due...7. Remove med from card or bottle...9. Physically and psychologically handle taking own			

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	meds...10. Maintain safe storage of medication as required by policy and state regulations." The assessment included a handwritten note which indicated, "Plan to contact [name of physician] and request order to allow staff to take over resident's medication." The Medication Self-Administration Assessment, dated 04/05/11, indicated Resident #2 "...at times is drowzy [sic] and has to be awakened to take her medications. Shields House staff have been administering medication..." The Nurses notes from 01/10/11 through 03/20/11 and lacked documentation that an order had been obtained for staff to administer medications. The Nursing Comprehensive Evaluation, dated 02/21/11, indicated, "QMA [Qualified Medication Aide] administering			

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	medication". The April 2011 MAR [Medication Administration Record] indicated Resident #2 received "Neurontin [for pain] 300 mg [milligrams] orally twice daily, K-dur [supplement] 10 meq [milli-equivalent] orally twice daily, Synthroid [hormone supplement]] 175 mcg [micrograms] orally daily, Metformin [for diabetes] 500 mg daily, Metoprolol [for blood pressure] 25 mg daily, Altace [for high blood pressure] 2.5 mg daily, Multivitamin [supplement] daily, Caltrate-600 with Vitamin D [for calcium replacement] daily, Celexa [for depression] 10 mg daily, Evista [for osteoporosis] 60 mg daily, Famotidine [for heartburn] 20 mg daily, Duragesic [for pain] 75 mcg every 72 hours, Lasix [for edema] 80 mg daily, Albuterol 0.083% [for asthma] by nebulizer twice daily, Trazadone [for depression] 50 mg at bedtime, Miralax [for constipation] 1 tablespoon in water			

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	daily." The 2010 Nursing Spectrum Drug Handbook page xiv was reviewed on 04/05/11 at 2:15 P.M., and indicated, "The 'five rights' of drug administration...to make sure you give the right drug, match the drug label against the order in the MAR three times-once when you remove the container from the patient's drug drawer, again before you remove the dose from the container and, finally, before you return the container to the drawer or discard it. Never give a drug from a container that is unlabeled..."			
R0295	(a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on interview and record review, the facility failed to ensure a resident followed the facility procedure for storing medications, in that Resident #8 stored narcotics on her walker making them accessible to other staff and residents for 1 of 5 residents	R0295	**Citation #4** **R 295** **410 IAC 16.2-5-6 (a)** **Pharmaceutical Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #8 was	04/28/2011

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	reviewed for medication storage in a sample of 7. Findings include: The clinical record for Resident #8 was reviewed on 4/5/11 at 1:00 P.M. The record indicated Resident # 8 had chronic low back pain related to degenerative arthritis. The physician orders, dated 3/15/11, indicated "Oxycontin [pain medication] 40 mg [one] BID [two times daily]." An investigation of missing of medications, dated 3/19/11, no time, indicated "3/19/11 Received call from (daughter name) concerning her mother's (Resident #8's name) medications. She stated that her mother's Oxycontin [a narcotic] had been replaced by what she said was a blood pressure pill. She called me later in the day, approx [approximately] 4:00 pm and said that after checking her mothers (sic) other medications that she had discovered that her		re-educated to our policy and procedure concerning self administration and storage of medication. Resident #8 is in agreement and was re-assessed by the Wellness and deemed capable of safe storage and self administration of medication utilizing the medication self administration assessment. Resident #8's physician was in agreement and an order was obtained for resident to keep medications in apartment and self administer. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director was re-educated to our policy and procedure regarding self administration of medication. Residents who self administer were re-assessed by the Wellness Director and re-educated to our policy concerning self administration and storage of medication. Residents found to be incapable of self administration and storage of medication will have the family and physician notified and the	

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	Oxycodone had been replaced with a diabetes pill (Metformin) and Aspirin. I made arrangements to meet with her the following day 3/20/11 at 4:00 pm. 3/20 Met with (Resident # 8's daughter name) and her mother (Resident # 8's name). I was given a bottle of Oxycodone that contained aspirin and an unknown pill which was later identified as Metformin. I interviewed (Resident # 8) and she said that she kept her medications in a basket in her walker. That an aide (CNA # 12 name) had taken her cart on Friday to clean it up for her. She stated that she had done the same thing about a month ago. The daughter said that she noticed that the count was off on her mothers (sic) last month, but thought the pharmacy had made a mistake on the count..." The policy and procedure for New Resident Medication/Treatment Record, dated 7/2009, indicated "...If the resident stores narcotics in his/her apartment, the narcotics		medications administered by the Residence with the service plan updated to reflect the provisions provided by staff. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director or Designee will perform an ongoing assessment of residents who self administer medications to ensure continued compliance no less than quarterly. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: May 15, 2011	

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	must be kept in a locking box (to which staff does not have a key) AND the apartment door or keyed cabinet must be kept locked..." In an interview with the Regional Nurse on 04/06/11 at 10:00 A.M., he indicated "They [the medications] should have been in a locked cabinet in her [Resident #8] apartment."			